Local Government Health Plan
BENEFIT CHOICE ELECTION FORM
May 31 – June 18, 2004 (Changes effective July 1, 2004)
COMPLETE THIS FORM ONLY TO MAKE A *CHANGE* IN YOUR BENEFITS

SECTION A: EMPLOYEE INFORMATION (required)

Social Security Number	Last Name	First Name	Phone Numbers
- -			Home:
			Work:

SECTION B: HEALTH PLAN ELECTION (complete only if changing health plans)

(1) If you are changing to a managed care plan from the Local Care Health Plan (LCHP), or if you are changing to a different managed care plan, you must enter the 6-digit Primary Care Physician (PCP) number.

(2) If you have Medicare or other insurance, you must give your Health Plan Representative (HPR) a copy of your Medicare/other insurance card.

HEALTH PLAN ELECTION			
☐ LCHP			
Managed Care Plans: ☐ HMO ☐ OAP	Carrier Code:____ (see page 7)	Plan Name:	6-digit PCP #:

SECTION C: DEPENDENT INFORMATION (dependent must enroll in the same plan as the member)

(1) You must provide documentation to add dependents – see the back of this form for specific documentation requirements.

(2) If the dependent has Medicare or other insurance, you must give your HPR a copy of the Medicare/other insurance card.

(3) If you are changing to a managed care plan from the LCHP, or if you are changing to a different managed care plan, you must enter the 6-digit PCP number for each dependent in your plan.

Health			Name	SSN	Birth Date	Relationship *	6-digit PCP #
Add	Drop	Change					
☐	☐	☐					
☐	☐	☐					
☐	☐	☐					
☐	☐	☐					
☐	☐	☐					

* Spouse, son, daughter, stepchild, adopted child

This authorization will remain in effect until I provide written notice to the contrary. The information contained in this form is complete and true. I agree to abide by all Local Government Health Plan rules. I agree to furnish additional information requested for enrollment or administration of the plan I have elected.

MEMBER SIGNATURE: _____ DATE: _____

HPR SIGNATURE: _____ DATE: _____

Give completed form to your HPR in your Unit by June 18, 2004.

BENEFIT CHOICE ELECTION FORM
INSTRUCTION SHEET

If you are keeping your current coverage elections, you do not need to complete this Benefit Choice Election Form.

SECTION A – EMPLOYEE INFORMATION:

Complete all fields.

SECTION B – HEALTH PLAN ELECTION:

Do not complete this section if you only want to change your PCP – you must contact the managed care plan directly in order to make this change.

If you wish to change your health plan, check the appropriate box - LCHP, HMO or OAP. If electing/changing managed care plans, you must enter the managed care plan name, the carrier code and the 6-digit PCP number. The carrier code can be found on page 7 of this booklet. The 6-digit PCP number may be found in the managed care plan provider directory or the plan's online website (see page 11 of this booklet for Plan Administrator contact information).

SECTION C – DEPENDENT INFORMATION:

Complete this section if you are adding or dropping health coverage for a dependent. If you are adding dependent health coverage, **you must provide the appropriate documentation as indicated below:**

Spouse	Marriage certificate
Natural Child through Age 18	Birth certificate
Stepchild	Birth certificate, marriage certificate indicating your spouse is the child's parent, and proof the child resides with you at least 50% of the time.
Adopted Child	Adoption certificate stamped by the circuit clerk.
Adjudicated Child	Court documentation signed by a judge.
Student	Birth certificate, Dependent Coverage Certification Statement (CMS-138)*, and verification of full-time student enrollment in an accredited school.
Handicapped	Birth certificate, Dependent Coverage Certification Statement (CMS-138)*, and a letter from the doctor 1) detailing the dependent's limitations, capabilities and onset of condition from a cause originating prior to age 19, 2) a diagnosis from a physician with an ICD-9 diagnosis code, and 3) a statement from the Social Security Administration with the Social Security disability determination.
* The Dependent Coverage Certification Statement (CMS-138) is available from your HPR.	

SIGNATURE:

You must sign and date the Benefit Choice Election Form and give to your HPR by **June 18, 2004** in order for your elections to be effective July 1, 2004. Dependent documentation must be submitted to your HPR within 10-days of the end of the Benefit Choice Period. If documentation is not provided within the 10-day period your dependents will not be added.